Chapter VI – Service Application Packet

At the time of this publication the Children's Long Term Support (CLTS) Waivers, which were approved by CMS in November 2003 have slight differences in the way a county is to submit new Waiver applications to BDDS. Detailed instructions for how to perform certain functions for the CLTS Waivers are not yet in this chapter of the manual. They will be added shortly. County Support and Service Coordinators are encouraged to contact their assigned Community Integration Specialist for additional guidance as it relates to the CLTS Waivers.

6.01 Service Application Packet Development and Content

Each applicant for Medicaid Waiver services must have a service application packet developed by the county agency and approved by Community Integration Specialists (CIS) from the Bureau of Developmental Disabilities Services (BDDS). It is important that county agencies submit service packets that contain all required components and also to assure that each component is accurate and complete.

There are required processes associated with developing the service packet, and several specific requirements that direct how the county must submit the packet to the Bureau. The information presented here describes the situation prior to the time when the applicant is receiving Waiver services. Other situations involve an applicant who is already receiving services that can be covered by the Waiver and is merely transitioning from a state or local funding source to Waiver funding. It is expected that all applicants approved for Waiver funding will benefit from going through the Waiver application process. For example, all applicants must be offered the opportunity to make informed choice of service providers, living arrangement and other areas of their service package. All applicants must be advised of any conflicts of interest that may be present in the service arrangement. In addition, all people must be offered an individualized, person-centered assessment and service planning process.

Unless instructed otherwise, two copies of each Service Application Packet are submitted directly to the CIS assigned to the respective county. To obtain a list of the Community Integration Specialist Staff and their county assignments contact the Bureau of Developmental Disabilities Services or visit the website address: www.dhfs.state.wi.us/bdds/cip/cipcodir.htm

Service Application Packets are to be submitted before Waiver services begin. To allow sufficient time for time for review and approval, county staff should submit the packets at least two weeks prior to the requested service start date.

Joint plan approval occurs when the applicant is a current long-term resident of one of the State Centers for the Developmentally Disabled. In this situation the county must submit an additional copy of the service packet to the appropriate State Center.

When the plan has been approved, the CIS sends a letter stating such to the appropriate county representative. The participant/guardian receives a copy of the same letter. Approval may be conditional, so it is wise for the recipient to carefully review each letter.

Each Service Application Packet submitted to BDDS for approval must contain the following elements:

1. The cover/authorization letter;
2. The person-centered assessment of the applicant's needs and preferences;
3. The Level of Care Determination (DDES 2256/2256a) (Appendix D and E) or computer-generated output page of the web based Long Term Care Functional Screen (LTCFS) (Appendix J and K));
4. The MA Waiver Eligibility and Cost-Sharing Worksheet (DDES 919) or CARES screens;
5. The Individual Service Plan document (DDES –445) Appendix I or equivalent;
6. The narrative summary;
7. The request for variance(s), if needed;
8. The request for approval of any housing modifications (as appropriate);
9. The L-1 screen print showing HSRS registration.

6.02 Cover/Authorization Letter

The county sends a cover/authorization letter as a part of each service packet. The cover letter is signed by a person the county has authorized to submit Waiver applicants service packets. Counties generally authorize their Support and Service Coordinators or the developmental disabilities or long term support coordinator to act in this capacity. When a county uses Support and Service Coordinators from contract agencies, the county must authorize the staff of that agency to serve as designated contacts for submission of service plans if the contract agency staff will act in this capacity. The cover/authorization letter must include the following elements:

1. the name of the applicant;
2. the name of specific Waiver being applied for;
3. the specific slot "type" the county intends to have the applicant use;
4. the date the county wants to start services [1];
5. any request for variance or request to waive any requirement (if applicable);
6. the number of the Waiver slot the prospective applicant will utilize together with comment on the origin of such slot (if applicable).

[1] Counties may start billing services provided to an otherwise eligible applicant to the Waiver no more than ninety (90) days before or after the date of the physician or nurse signature on Form 2256a. For counties using the LTCFS, the Waiver start date can be no

earlier than the screen completion date entered in the computer. This date field is defined and contained on the LTCFS.

6.03 Assessment

A. Purpose of the Assessment

The Support and Service Coordinator completes the assessment. The assessment is a description of the applicant's status at the time he/she applies for Waiver services as well as a review of the person's goals, talents, etc. Information should be obtained directly from the applicant and the people who are close to him/her. The staff person doing the assessment should solicit guidance from the applicant regarding whom to include as an information source. The assessment process should be conducted in a way that encourages the applicant to express his/her needs and preferences for how and where he/she wants to live and what he/she prefers to do during the day and night. Counties should use a person-centered approach throughout the assessment process. The assessment should create a complete picture of the applicant's life.

The assessment is a vital part of the application, plan and plan review process. Assessments should be continually updated as the person's situation changes. New information obtained is used to update the assessment and should serve as the base to build revisions to the participant's individualized service plan. Each person completing the assessment should understand the importance of the following values while completing the assessment. These values should be reflected in the final written product and are intended to be the foundation of the written assessment:

1. Individual autonomy and self-determination
2. Individuality
3. Protection of and respect for rights
4. Lives that remain stable; people should experience continuity
5. Continuous growth and learning
6. Community presence and maximum community participation
7. Relationships with other people
8. Respect for personal preferences and an individual's chosen outcomes
9. People make informed choices based on complete information

B. Content of the Assessment

The assessment should contain information obtained during face-to-face interviews with the Waiver applicant as well as contacts with the guardian (if any), family, friends and other people who are significant in the prospective Waiver participant's life. The assessment should also consider records and related information obtained from previous service providers. While the review of such records is important, assessments should not be solely based on the review of the written record. Written records often do not give a comprehensive view of the individual nor serve to identify his/her preferences.

The assessment must include an exploration of the potential community alternatives and places where the applicant may want to live. It should include a discussion of how these relate to the applicant's needs and preferences. The assessment must

identify the informal and formal supports and/or services that are necessary to meet the applicant's needs. The assessment should include a statement regarding the individual's preferences regarding where to live, what type of supports are preferred, the specific choice to live in the community or in an ICF/MR, the social or roommate situation the applicant prefers, and the applicant's preferences for a particular service and service provider. Other content areas include any lifestyle choices of the applicant and the degree to which the applicant chooses to direct and manage services.

The assessment should identify the individual's preferences for service delivery and outline all lifestyle choices. The following list includes the topical areas that should be explored and documented as a part of the assessment:

1. Background information;
2. Social history;
3. Description of physical health and medical history;
4. Ability to perform physical activities of daily living;
5. Ability to perform instrumental activities of daily living (e.g. laundry, cooking, cleaning);
6. Emotional functioning;
7. Cognitive functioning;
8. Behaviors that positively or negatively affect lifestyle and relationships;
9. Social participation and existing formal and informal social supports;
10. Cultural, ethnic and spiritual influences including death and dying;
11. Current friendships;
12. Community participation and involvement;
13. Personal preferences for how and where to live and what to do during the day and night;
14. Risks associated with chosen behavior;
15. Future plans including ability to direct his/her own supports;
16. Preference for physical environments;
17. Economic resources available, and how they are managed;
18. Formal or informal supports that are currently available;
19. Need for long term community support services as an alternative to institutional care; and
20. Rights and the person's ability to understand them and assert them.

C. Format of the Assessment

The Department does not mandate a specific format for the assessment. Counties are encouraged to use a format that addresses the above list of topics. There are also a variety of good tools that can be used, and there will be new tools available in the future. All tools selected for use should be based on or be compatible with the principles of person-centered planning. Each tool has specific strengths and weaknesses. Some are more comprehensive than others. If the person completing the assessment chooses to use a tool and the scope of the tool does not include the

assessment areas above, the assessment must be supplemented with information that addresses the required content of the assessment.

During the assessment process the assessor may obtain reports or documents that provide the required information. These documents may be included in the assessment to address required content but may not serve as the complete assessment. Information about the participant which "everyone knows" is not evident to outside reviewers/auditors unless it is included in the written assessment.

6.04 Service Planning

Completing the assessment and planning services to meet the needs identified in the assessment are distinctly separate tasks. The assessment task is by definition limited to collecting information.

Information collected in the assessment is the foundation for developing a package of services and supports for each applicant. The plan of services shows the county response to the needs identified in the assessment. There are several person-centered planning processes that do a very adequate job of effectively matching specific needs with supports.

Support and Service Coordinators must do their best to listen to and actually know the applicant. Through these activities, the Support/Service Coordinator can facilitate creating a plan that includes the supports that permit the person to live and participate in the community with as much dignity as possible. Having this type of knowledge of the individual applicant makes it possible to facilitate decisions about what is needed to assure the applicant’s health, safety and welfare.

The Department does not prescribe a specific service planning process. As such, there is no prescribed state form associated with this step of the service development process. Each county is able to select its own service planning process. It is expected however, that whatever strategy used will be free of conflict of interest, based on person centered-ness and informed choice, address actual assessed need, and be inclusive of both formal and informal supports. The practice of offering service to an individual based solely on the “opening” or “vacancy” of a particular provider is not acceptable service planning. Counties are expected to take steps to develop additional service options around the needs of the person when there are limited or no providers available to meet assessed needs. New provider development takes on many forms and is an integral part of the long-term care system.

When service planning is complete, the plan will identify each area of need noted in the assessment and will have a corresponding description of the manner in which all needs will be met.

6.05 Level of Care (LOC) Determination

A. LOC Determination for CIP 1A and CIP 1B

There are currently two ways of securing a LOC for the Waiver applicant. Counties may use the LOC form (DDES-2256 and 2256a) (refer to D and E) to obtain a level of care or, they may use the electronic Long Term Care Functional Screen (LTCFS) (see Appendix J and K). The electronic version of setting level of care is only available to Support and Service Coordinators who have become certified in using the LTCFS.

The Department will require all counties currently operating CIP 1A and CIP 1B to begin using the Long Term Care Functional Screen (LTCFS) to determine eligibility and level of care for those programs effective January 1, 2005

1. The LOC Form (DDES-2256 and 2256a)

The service plan packet submitted to BDDS must include a complete copy of the rated LOC Form. To obtain a care level rating using this form, the Support and Service Coordinator submits a completed form along with the cover page requesting care level assignment to their regional Bureau of Quality Assurance (BQA). Obtaining the appropriate care level verifies that these Waivers are serving only persons who, if institutionalized, would be eligible for Medicaid reimbursement at the ICF-MR level of care. The criteria used in determining level of care for the Waivers are located in Appendix L. The only exception to this procedure is for an initial level of care rating for applicants who are leaving one of the State Centers for the Developmentally Disabled. In this case, State Center staff assigns the initial care level to the applicant.

When completing this form, the county staff places a check mark in the appropriate box “MA Waiver Application” on page 1. County staff may attach additional information they believe will assist BQA in awarding a proper care level. It is important to provide complete, current information, including:

a. All diagnoses.
b. All medications and treatments (prescription and over-the-counter).
c. All assistance including therapies and maintenance assistance (e.g., range of motion exercises) currently provided by health care professionals, family or friends.
d. A copy of any assessments or narratives that contain pertinent medical/health/behavioral information.
e. Other useful information such as a recent discharge summary, nursing or therapy notes.

The county should attach a cover letter to all forms they send to BQA. This letter should describe any special considerations that apply to the applicant's situation. The letter should also identify to whom the rated form should be returned.

The initial LOC Form must be signed by a physician or a registered nurse within 90 days before or 90 days after the applicant's intended Waiver start date.

2. The Long Term Care Functional Screen (LTCFS)

The second way level of care can be determined is by using the LTCFS. The LTCFS is a web-based tool that is programmed to determine the applicant's level of care. Use of the LTCFS tool is expanding and in the future it will be the only way to have the Waiver applicant's care level established.

Counties using this method complete the LTCFS as part of the application process, and send a copy of the tool's output page as a part of each service packet. These county staff do not complete DDES Form 2256 and DDES Form 2256a. Each person using the tool must have completed the Department's training and been certified to use it. Counties that do not use this tool continue to complete form DDES-2256 and 2256a.

B. Level of Care for BIW

The Brain Injury Waiver requires Bureau of Developmental Disabilities Services staff rate the Level of Care on an annual basis. Persons with this care level often have needs for cares that change. Current hospital, physician and therapy reports are often very useful in the rating process and help the staff assign the most accurate care level possible. The Support/Service Coordinator mails DDES Form 2256 and 2256a along with a request for LOC to:

BIW LOC Contact
The Bureau of Developmental Disabilities Services
Room 418. 1 West Wilson Street
P.O. Box 7851, Madison WI. 53707.

As is the case with all other forms being sent to an office, please include a cover letter explaining the request and identifying to whom any questions should be directed and identify to whom the rated form should be returned. Refer to previous pages in this Chapter and also to Chapter VII for details on submitting this form to BDDS.

6.06 MA Waiver Eligibility and Cost Sharing Worksheet or CARES Screen

Chapter III contains detailed information on the financial eligibility process as it applies to each applicant who applies for Waiver services. When the applicant is eligible

through Group A, the DDES Form 919 worksheet must be submitted as a part of each service application packet. This form has detailed instructions contained within it, and is located at Appendix A.

All other financially-eligible applicants must have a Client Assistance for Reemployment and Economic Support (CARES) screen print included in the packet sent to the BDDS. The county Economic Support Unit determines Medicaid eligibility for those people not already receiving Medicaid. The Economic Support workers also determine financial eligibility for applicants who participate in Medical Assistance Purchase Plan (MAPP) Program.

6.07 Individual Service Plan Form (DDES Form 445 or Equivalent

> **Note: There are two versions of DDES Form 445 in Appendix I. The first version is the approved form used in the CIP 1A, CIP 1B and BI Waivers. Counties operating those Waivers may continue to use this version of the form until further notice. They may also use the second version of the form if they choose pursuant to the instructions in this note. Counties may also continue to use their own version of this form so long as it is approved by their CIS.**
>
> **The second form was developed for the CLTS Waivers. It has check boxes for the three CLTS Waivers so it, or a suitable substitute developed by a county, can be used for those Waivers. The major difference between the forms is a section on outcomes. Since we do not have instructions for this section available at this time and have not yet made this a subject of training for Support and Service Coordinators, county staff may leave this section blank at this time.**

The Individual Service Plan (DDES Form 445) lists all services that will be provided to the applicant. It is intended to give a picture of all supports and services, not just Waiver services. The Individual Service Plan is the summary of the applicant's proposed package of supports and service. The provider list on the Individual Service Plan includes all services that will be used to meet the needs of the individual whether the Waiver or some other source funds them.

The DDES 445 should contain information on all Waiver, medical, dental and other services necessary to adequately maintain the participant in the community and ensure health and safety. The plan shall also contain information on how the Waiver participant's financial and other economic resources and property will be managed.

The participant/guardian and the Support/Service Coordinator must sign each completed Individual Service Plan. The applicant signature signifies that he/she is in agreement with the plan as written, and that he/she has been advised by the county of the right to accept/reject any or all parts of the plan, and that he/she has been advised of his/her right to choose between receiving services in the community or at an institution.

The county may use its own version of the Individual Service Plan with approval from the Department. The Department requires that any replacement document contain at least all of the information contained in the DDES Form 445.

The Individual Service Plan is a primary form used during an audit and other administrative review processes. The Individual Service Plan serves to confirm that the person/guardian agrees with the services contained in the plan.

The Individual Service Plan must be updated when needs or services change (see Chapter VII). Such changes are often made at the conclusion of regular reviews or in response to critical incidents. While regular reviews are required, the participant, his/her guardian or the Support and Service Coordinator may also initiate a review of the Individual Service Plan at any time.

A. Content of the Plan

The completed plan, DDES Form 445, identifies the participant name, address, telephone number and Medicaid number. The plan lists the name and address of all of the providers that were selected to provide all of the services and supports in the plan. The plan also includes the start date of the plan and each service, authorized amount of service expressed in units, the cost and the source of funding that will be used to pay for the service. Some plans use an authorized level of services while others use a maximum amount authorized. If the maximum is used, this should be specified on the plan.

The Individual Service Plan must contain information that accurately reflects all pertinent aspect of the applicant's financial situation. Any required cost-share must be listed on the plan identifying with the specific Waiver service to which the cost-share is being applied. The amount of room and board the applicant will pay as well as the applicant's projected amount of personal discretionary spending must also be listed on the Individual Service Plan. Refer to Chapter III for details regarding cost-share, personal spending and any other participant-specific financial questions.

The following specific information is required on the Individual Service Plan form:

1. The reason for the Individual Service Plan (new applicant or recertification);
2. All requested demographic information;
3. The actual date the plan was developed with the participant;
4. The monthly room and board amount being paid together with the payment source;
5. The actual amount of money the applicant has for monthly personal discretionary spending;
6. The name, frequency and type of each informal support that is or will be involved in supporting the applicant in the community;
6. The name of each paid support or service, the service code, the units to be provided and the unit cost of each service.;
7. The name, address and telephone number of each service provider ;

8. The start date (and end date as applicable) of each service;
9. In addition to the number of service units, any planned or anticipated variability in the frequency, or duration of any service or change in regular schedule;
10. The daily cost of each paid service (annual cost divided by 365 days);
11. The funding source of each service. Separate funding sources must be listed on separate lines on the form unless the source is used for Waiver match. If used as match, list the name of the funding source first and then list the name of the Waiver (e.g. FSP match- CIP 1B);
12. The daily rate of the plan (total annual expense divided by 365);
13. The agency, specific staff person and telephone number responsible for Support and Service Coordination;
14. The agency or person responsible for managing the participant's personal funds; and
15. The authorizing signature of both the applicant/guardian and the support/service coordinator.

B: Plan Requirements

1. When the participant has a monthly cost-share obligation the plan must clearly show the Waiver services to which the monthly cost-share is being paid.
2. The funding source to be used for room and board costs must be identified on the plan. Separate entries are required for each source used to support room and board. Use of the individual's personal funds for room and board must also be specified if the county agency is involved in the management of these funds. Medicaid Waiver dollars may not be used for room and board.
3. The amount of personal spending available to the applicant must be specified. The calculation of resources available for personal spending involves first deducting any cost-share the participant is required to pay and then subtracting room and board expenses from the applicant's total monthly income. The result is the amount, which must be available for the participant's monthly personal spending.
4. Participant contributions toward the cost of any service must conform to Section 3.05 in Chapter III of this Manual. All participant contributions shall be clearly listed on the Individual Service Plan in the column titled "funding source".
5. The participant must continue to be fully informed of the content of and any changes to his/her service plan. The participant must also have his/her rights and responsibilities presented and explained to him /her both verbally and in writing. Required notifications and required updates of these notifications are the responsibility of the Support and Service Coordinator.
6. When the participant or the guardian of the participant refuses to sign the plan, the plan will not be considered to be approved unless the plan is required by a protective placement order under Chapter 55, Wisconsin Statutes or the comparable provisions under Chapter 48, when the participant is a child. A copy of the court order must accompany the plan submitted to BDDS. The county is expected to explore mediation, negotiation and compromise before submitting unsigned plans.

7. When the authorized representative signs the plan on behalf of a Waiver participant, a completed ISP Authorized Representative Form (DDES Form 987) must be maintained in the participant's county file. A link to and copy of this form can be found in Appendix O.

6.08 Service Plan Narrative

The service plan narrative is a distinct section of the service application packet. The narrative is written based on the content of the participant's Individual Service Plan. The purpose of the narrative is to clearly communicate detailed information surrounding the applicant's proposed service delivery. The narrative provides a detailed explanation of how the services included on the Individual Service Plan will meet all of the applicant's assessed need(s).

When the applicant has challenging behavior, the approach used to support the person must be explained in the service plan narrative. This may include copies of specific service or behavior support plans that have or will be used. If the participant requires the use of restraints or other restrictive measures of any kind, the reason for the restraint or restrictive measure and the manner of its use must be described in written detail. Materials used for the restraint approval process may be used if they respond to this documentation requirement. Guidance on the restraint approval process can be found in both Chapters VIII and IX of this Manual.

When the applicant's assessment identifies the need for which a service, support or intervention is to be provided, the service plan narrative should describe how that service addresses the need. For example, when the assessment identifies that the person tends to wander from home, the narrative should identify the planned strategies the provider will use to assure that the person will be kept safe from the consequences of this behavior. If the assessment identifies a behavior that places the person at risk of harm to his/her self or to others, the narrative together with a behavioral treatment/support plan will provide a detailed explanation of how the behavior will be addressed to reduce the risk of harm.

6.09 L1 Screen

The printed L1 Screen must be included in each Service Application Packet sent to the BDDS. This screen verifies that the applicant has been registered onto the Human Services Reporting System (HSRS) and permits BDDS to assign the person a funding slot (See Chapter XI for a discussion on slots and slot assignment). BDDS will not approve the applicant for participation until after the person is registered onto the HSRS.

6.10 Request for Variance(s)

There are two special situations when a request for a variance must be included with the Service Application Packet sent to BDDS. It is the responsibility of the Support and Service Coordinator to include any required "application for variance" with the participant's Service Application Packet. The two potential variance situations are:
If an individual's plan indicates he/she will live in and be served by a Community Based Residential Facility (CBRF) that is licensed for eight (8) or fewer beds, or when a service in the applicant's plan will be provided on the grounds of an institution. Institution in this context refers to nursing homes, ICFs/ MR, hospitals or Residential Care Center for children.

If after approval of the person's initial plan, the participant contemplates moving to a CBRF or initiating services with a provider that provides services on the grounds of an institution, the Support and Service Coordinator should submit the variance request for approval. In order for continued funding to be assured the variance must be submitted prior to the start of the service that necessitates the need for a variance. When the need for the variance is sudden and unanticipated, the BDDS may approve the variance on a retroactive basis. Such situations require written documentation explaining the reason(s) retroactive approval is necessary. Advance discussion with the county's assigned CIS is strongly encouraged. When a situation that requires a variance has no approved variance it is grounds for terminating Waiver funding for the participant. All requests for variances should be sent to the county's assigned CIS and must include an updated Individual Service Plan. The procedure for applying for and the criteria used to grant a CBRF variance are located in Chapter V.

For variances involving services on the grounds of institutions to be granted, the prospective service must be determined to be "less restrictive" than another comparable service available in the community or be sufficiently unique that an individual's needs do not appear to be able to be met by any other provider in reasonable proximity to the person. Under no circumstances may a Waiver participant reside on the grounds of an institution. Any variance approved is always specific to the person for whom the variance is sought and applies only to the specific provider and setting that was the subject of the request. Time limits will be applied to all variances. Other conditions of approval may also be placed on the approval if granted.

The following information must accompany each request for variance involving services on the grounds of institution:

(1) The specific reason(s) for the request,
(2) A description of all community-based services of a similar nature available and a description of each specific barrier to using them,
(3) A description of the proposed services,
(4) A description of the specific plans to address the limitations associated with institutional settings.

6.11 Home Modifications

Home modifications are a service covered by the Waiver that may be provided to the participant if there is an assessed need. This service must be listed on the Individual Service Plan and must be described in the plan narrative in sufficient detail so as to document that it is appropriate and necessary for the participant. A home modification that costs less than $1,000 is not subject to any special approval. Home modifications costing $1,000 or more are subject to review and approval by BDDS. When the home modification is included as a part of the applicant's original service plan, approval will be included in the plan approval letter. Whenever a home modification is identified on an Individual Service Plan update, approval must be done as a separate process and will be provided via separate letter from BDDS.

When the county seeks approval for a home modification, the request for approval must include:

1. A description of the proposed modification;
2. An explanation of why it is needed;
3. A photograph or plans that illustrate the modification;
4. A written estimate of the cost of the modification, which includes a statement of the maximum cost, expected.

A separate approval process for home modifications that involve the addition of space to the person's home is detailed in Chapter IV in the service descriptions for the SPC "Home Modifications". The Support/Service Coordinator may submit the request for approval at the time of Waiver application or as a part of an Individual Service Plan update.

6.13 COP Functional Screen

Counties using the LTCFS are not required to also complete a COP Functional Screen on each applicant. As of January 1, 2005, the COP Functional Screen will no longer be required for Waiver applicants. Counties not yet using the LTSFS must continue to use the COP Functional Screen whenever COP funds are used (including as local match) to fund any Waiver-covered service.

The COP Functional Screen is signed by an approved professional, including a Social Worker, nurse (RN or LPN) or Support and Service Coordinator. For purposes of the COP Functional Screen, the definition of Social Worker is "a person who practices Social Work as defined by Chapter 457, Wisconsin Statutes and is certified by the Department of Regulation and Licensing under that Chapter." The COP Functional Screen can be found in Appendix F.